Parker Pediatrics & Adolescents, P.C.
Patient Information - Family Form

MyChart by Epic

PATIENT DATA – FULL LEGAL NAME

- The "Family Form" can be used if all children in the family have the same information. PLEASE LIST EACH CHILD IN FAMILY BELOW
- If foster care, blended family, or separation/divorce, please complete individual forms for each child.
- If you are a patient 18 or older – List ONLY yourself and your contact information.

OFFICE USE	Last Name	First Name	Middle Initial	Date of Birth M M / D D / Y Y	Gender	Child Resides With
☐				/ /	☐ Male ☐ Female	☐ Mother ☐ Father ☐ Both
	☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown ☐ Decline to Answer				☐ Not Hispanic/Latino ☐ Hispanic/Latino	☐ Decline
☐				/ /	☐ Male ☐ Female	☐ Mother ☐ Father ☐ Both
	☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown ☐ Decline to Answer				☐ Not Hispanic/Latino ☐ Hispanic/Latino	☐ Decline
☐				/ /	☐ Male ☐ Female	☐ Mother ☐ Father ☐ Both
	☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown ☐ Decline to Answer				☐ Not Hispanic/Latino ☐ Hispanic/Latino	☐ Decline
☐				/ /	☐ Male ☐ Female	☐ Mother ☐ Father ☐ Both
	☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown ☐ Decline to Answer				☐ Not Hispanic/Latino ☐ Hispanic/Latino	☐ Decline

TELEPHONE NUMBERS

- **Primary phone (#1) is the one to be used for messages and reminder calls**
- **Please list phone numbers in order to be called.**

#	Number	Type	Whose	
1	___ - ___ - ____	☒ **Cell Only**	☐ Mother ☐ Father	☐ Patient (18 Yrs and Older) ☐ Other ____________
2	___ - ___ - ____	☐ Cell ☐ Home	☐ Mother ☐ Father	☐ Other: ____________
3	___ - ___ - ____	☐ Cell ☐ Home	☐ Mother ☐ Father	☐ Other: ____________

BILLING ADDRESS & FINANCIAL INFORMATION

Name of Financially Responsible Person (1)
Bills mailed to this person. MUST sign form. ____________________

Billing Address ____________________ Apt / Unit # ______
Update to Existing ☐

City ____________ State ____________ Zip ____________

PARENT / GUARDIAN INFORMATION – FULL LEGAL NAME

Contact ____________________ DOB ___ ___ / ___ ___ / ___ ___
Last Name First Name MI M M D D Y Y

☐ Single ☐ Married ☐ Divorced ☐ Widowed **Relationship to Child:** ☐ Mother ☐ Father ☐ Stepparent ☐ Foster/Guardian

Physical Address
(if different from above) ____________________

E-Mail Address ____________________
Employer / Occupation ____________________

Contact ____________________ DOB ___ ___ / ___ ___ / ___ ___
Last Name First Name MI M M D D Y Y

☐ Single ☐ Married ☐ Divorced ☐ Widowed **Relationship to Child:** ☐ Mother ☐ Father ☐ Stepparent ☐ Foster/Guardian

Physical Address
(if different from above) ____________________

E-Mail Address ____________________
Employer / Occupation ____________________

Custodial parent, if applicable: ____________________
Stepparent's names, if applicable:
** Complete Care Authorization If Needed*

MISCELLANEOUS

Emergency Contact (other than above) ____________________ Phone ___ - ___ - ____
Former Pediatrician (if applicable) ____________________ Referred by ____________________

Parent / Guardian / Patient Signature ____________________ Date ____________

Printed Name of Signer ____________________

(1) If parents are not married, or are divorced, the financially responsible party must sign this form to accept responsibility

Patient Name(s): Date(s) of Birth:	

Please List All Names on Top of Form / Read and Initial All Boxes / Sign and Date at Bottom

INSURANCE DATA

☐ **No change to Insurance (for existing patients only)**

Effective Date	/ /
Insurance Company Name Aetna ☐ BCBS ☐ Bright Health ☐ Cigna ☐ CHP ☐ Cofinity ☐ Humana ☐ Medicaid ☐ Tricare ☐ United ☐ UMR ☐ Other ☐	
Name of Insurance, if not listed above:	
Insurance Claim Address	
City / State / Zip	
Insurance Phone Number	- -
Policy Holder Name	
Relationship	☐ Parent ☐ Step-Parent ☐ Other: — Policy Holder DOB / /
Address – If Different from Patient / Parent	
Insurance ID #	
Group #	

VACCINE POLICY / CONSENT FOR PAYMENT / ASSIGNMENT OF INSURANCE BENEFITS / PRIVACY POLICY

VACCINE POLICY

☐ Initial

*I understand that Parker Pediatrics & Adolescents **only** accepts patients into the practice who agree to meet the minimum recommended vaccination schedule/timetable and that any child(ren) who may be behind on vaccines will be brought current as soon as possible.*

CONSENT FOR PAYMENT

☐ Initial

I understand that I am financially responsible for all professional charges that my child(ren) may incur. Payment for these services is due at the time of service. Patients covered under a contracted insurance plan are required to pay any co-payment, deductible, or co-insurance at the time of service or promptly when billed.

*I understand that **Insurance/Medicaid Cards should be presented at EVERY VISIT**.*

☐ Initial

*I hereby authorize direct payment of surgical/medical benefits to **Parker Pediatrics and Adolescents, P.C.**, for service rendered. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize **Parker Pediatrics and Adolescents, P.C.** to release any medical or incidental information that may be necessary for either medical care or processing applications for financial benefit.*

☐ Initial

*Divorce has no bearing on the responsibility for medical care as it affects third parties. **WHOEVER BRINGS THE CHILD IS EXPECTED TO PAY THE CHARGES DUE FOR THE SERVICE RENDERED THAT DAY.** Parker Pediatrics & Adolescents does not participate in payment disputes between parents.*

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES / COMMUNICATION CONSENT

☐ Initial

I have received, or have been given the opportunity to receive, a copy of the **HIPAA Notice of Privacy Practices for Parker Pediatrics & Adolescents, P.C.**

☐ Initial

I give "consent" to Parker Pediatrics and Adolescents to communicate with me regarding my child's health via text messaging.

E-MAIL PERMISSION

☐ I presently receive Parker Pediatrics emails

☐ I **DO** wish to be included in the Parker Pediatrics e-mail distribution list to receive occasional brief announcements and timely information. (***Strongly recommended in order to receive flu clinic dates, local epidemics / infection reports, office policy changes, and the link to our quarterly electronic newsletter.***)

Please use the following as my preferred email address:

*

I understand that I may opt out at any time, that this information is NOT shared with third parties, and is for the exclusive use of Parker Pediatrics.

☐ I **DO NOT** wish to be included in the Parker Pediatrics e-mail list.

The above information is current and correct.

Parent/Guardian/Patient Signature _____ Date _____

PARKER PEDIATRICS & ADOLESCENTS, P.C.

NEW PATIENT MEDICAL INFORMATION SHEET

(Please Print)

Newborn History

Name:	DOB:	Phone:
☐ Parker Adventist ☐ Sky Ridge ☐ Other:		OB:
# of Pregnancies:	# of Live Births:	Length of Pregnancy:
Pregnancy Problems:		
Delivery: ☐ Vaginal ☐ C-Section (Reason):		
Delivery Problems:		
Apgars: /	Mother's Blood Type:	Baby's Blood Type:	Coombs:
Nursery Problems:			

Birth Weight: lb oz	Length:	Head Size:	Discharge Date:	Discharge Weight:	Feeding: ☐ Breast ☐ Bottle

Family Health History

	Age	Health Problems	Smoker	Height	Weight
Father (of Patient)			☐		
Grandfather			☐		
Grandmother			☐		
Mother (of Patient)			☐		
Grandfather			☐		
Grandmother			☐		
Sibling(s) (of Patient)			☐		
			☐		
			☐		

Diseases or Problems in Family or Close Relatives, Including Infant Deaths and Birth Defects: ☐ None

Patient's Medical History – Attach Additional Documentation As Needed

Hospitalizations/surgeries (type, where, when) ☐ None

Injuries: ☐ None

Major Illnesses or Chronic Problems: ☐ None

Allergies: ☐ None

Daily Medications: ☐ None

Development: ☐ Normal ☐ Delayed / What Areas:

Immunizations: **Attach record from previous provider / state registry. Please bring to first office visit.**

Systems Review

(Answer "Yes" if these are chronic or ongoing problems)

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Headaches	☐	☐	Vomiting	☐	☐	Birthmarks	☐	☐	Bruising	☐	☐	Dizzy Spells	☐	☐
Diarrhea	☐	☐	Fainting Spells	☐	☐	Constipation	☐	☐	Nosebleeds	☐	☐	Seizures	☐	☐
Stomach Pain	☐	☐	Hyperactive	☐	☐	Weakness/Paralysis	☐	☐	Painful Urination	☐	☐	Speech Problems	☐	☐
Visual Problems	☐	☐	Menstrual Cramps	☐	☐	Behavior Problems	☐	☐	Hearing Problems	☐	☐	Bedwetting	☐	☐
Learning Problems	☐	☐	Ear Infections	☐	☐	Swollen Joints	☐	☐	Chest Pain	☐	☐	Limp	☐	☐
Coughing	☐	☐	Acne	☐	☐	Shortness of Breath	☐	☐	Dental Problems	☐	☐	Attention Disorder	☐	☐
Strep Throats	☐	☐	High Blood Pressure	☐	☐	Appetite Problems	☐	☐	Heart Murmur	☐	☐	Other	☐	☐

Parker Pediatrics and Adolescents, P.C.
Financial Policy

Parker Pediatrics and Adolescents, P.C. (PPA) wants to be sure that you understand our responsibility to you and your insurance company as well as your financial responsibility to us. Please read this carefully, ask further questions if needed, then sign.

We participate with the following insurance plans: **Aetna, Anthem/Blue Cross Blue Shield, Cigna, Colorado Children's Health Plan (CHP), Cofinity, Colorado Health Neighborhood, Humana, Medicaid, Rocky Mountain, and United Healthcare**. If you are not a member of one of our contracted plans, we will be happy to see you under a fee-for service agreement. Payment is expected to be paid at the time of service and you will receive a copy of the fee slip to submit to your plan. We offer a discount for anyone who pays for their visit in full at the time of service.

It is your responsibility to understand your particular plan as well as any health savings plans you may have in effect. According to your insurance plan, you are responsible for any copays, deductibles, coinsurance or non-covered services. Copays are due at the time of your visit.

Credit Card on File

This is the most convenient, cost effective and green method for paying any balances due on your account. You can be assured that your credit card information will be safe and secure in the encrypted merchant services vault with Authorize.Net. Once the information has been received, it will be secured in a lock box until it is ready to be entered into our credit card system. We will then shred the information and from that point forward, will only have access to the last 4 digits. We accept Visa, Mastercard, American Express and Discover.

Your insurance company will be billed and when we receive payment from them, any balance due by you will be applied to your credit card which may not be for another 30 days as most insurance claims take 2 to 3 weeks to process. PPA will only utilize your credit card on file for balances due on your account. If you choose not to give us a credit card to keep on file, then it is expected that you will pay your statement promptly upon receipt. We offer online bill pay as well.

The maximum amount that would automatically be charged to your credit card is $200. For accounts with balances over $200, we will charge the first $200 and then you will be notified of the balance for permission to charge your credit card with the balance or to make payment arrangements.

Please be assured that if there are financial difficulties which preclude you from settling your account, we are more than happy to work with you but you must communicate this to us and make a plan with our Business Office. Also be aware, that unless you have a credit card on file, the adult who accompanies the patient or the unaccompanied adolescent will be responsible for copayments.

Cancellation Policy

Well visit/annual exam and asthma appointments require a 24 hour cancellation notice and all psychology appointments require a 48 hour notice. Late cancellation/no show fees respectively range from $65.00 to $85.00. Under certain circumstances, patients may be discharged from our practice in lieu of this fee.

Collections

If there are financial difficulties, we will work with you to allow uninterrupted care for your child(ren). If, however, you fail to respond to your financial obligation either by payment or arrangements with our Business Office, we will need to enforce our collection policy. This could involve your account being turned over to our collection agency, collection fees assessed and dismissal from our practice.

Name: _____ Date: _____

Name of Child/Children: _____

Signature: _____

PARKER PEDIATRICS & ADOLESCENTS, P.C.

Serving the Parker community since 1982

10371 Parkglenn Way, Suite 100
Parker, Colorado 80138
Telephone: 303-841-2905
Fax: 303-841-3052 / fax@parkerpediatrics.com

Website: www.parkerpediatrics.com

DO NOT RETURN THIS FORM TO PARKER PEDIATRICS,
IT NEEDS TO GO TO THE PREVIOUS PROVIDER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Former Physician:			
Name of Physician/Practice			
Mailing Address	Street Address		
	City	State	Zip
Email			
Telephone		Fax	

I have transferred my child(ren)'s medical care to the practice below and hereby request that my child(ren)'s medical records be sent to:

Parker Pediatrics & Adolescents, P.C.
10371 Parkglenn Way, Suite 100 | Parker, CO 80138
Fax: 303-841-3052
fax@parkerpediatrics.com

☒ Please include ALL records related to patient care at your facility, including but not limited to immunizations, office visits, labs, consults, hospital/ER.

Effective Date of Release	

Patient Name	**Date of Birth**

If you require a different form in order to transfer these records, please send to:

Patient's Present Address	

I understand that the information to be released may include the following conditions, if present: drug or alcohol abuse, psychological or psychiatric conditions, HIV or AIDS testing or diagnosis. I wish to exclude the following records from being released:

This is a one-time authorization and will expire in 60 days. During this period, this release may be revoked by written notice.

Parent's Signature		Date	
Printed Name			